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**Written Testimony of the Connecticut Orthopaedic Society**
**HB 5361 - An Act Limiting Changes to Prescription Drug Formularies and Lists of Covered Drugs**
**HB 5366 - An Act Concerning the Cost of Prescription Drugs**
**Insurance and Real Estate Committee – Tuesday, March 3, 2020**

Senator Lesser, Representative Scanlon and distinguished Members of the Insurance and Real Estate Committee, on behalf of the more than 200 orthopaedic surgeons of the Connecticut Orthopaedic Society, thank you for the opportunity to submit written testimony on **HB 5361 - An Act Limiting Changes to Prescription Drug Formularies and Lists of Covered Drugs** and **HB 5366 - An Act Concerning the Cost of Prescription Drugs**

We are writing to share our Society's support of both bills and to extend the orthopaedic community's collective thanks to the Committee for initiating this bill seeking to protect consumers from health insurers' egregious practices of changing the terms of a health care insurance contract during a coverage period. Both of the bills being heard before you today are pro-consumer, patient-centered bills that will benefit our patients and relieve them of the burdensome insurance practices and policies that are harmful to their care and treatment. In addition, HB 5366, includes pricing protection for consumers which the orthopaedic community also supports.

Our Society raised this issue during the 2018 legislative session in response to the abrupt and arbitrary removal of viscosupplementation coverage from the Anthem/Blue Cross Blue Shield's formulary, during an insurance coverage period and without prior notification to the patients. Since the treatment often consists of a series of weekly injections, patients were left without coverage in the middle of a treatment cycle. We submitted testimony on Raised Bill 212 and also shared the written testimony of a patient who suffered from the insurer's abrupt change in policy mid coverage that had a significant impact on him, disrupted his treatments, and interfered with his pain management.

The patient's written testimony from 2018 is excerpted below as it emphasizes the harmful impact mid contract drug changes have on our patients.

"I have what has been termed as bone on bone arthritis in my knee and Dr Ripps has been treating me with hylaronic acid injections. These treatments have helped me to remain mobile and relieve pain without using dangerous addictive medications and to postpone joint replacement surgery at this time. I am an insulin dependent diabetic of 41 years which seriously slows and complicates healing therefore surgery in any form should be avoided unless absolutely necessary.

Unfortunately Anthem no longer covers this treatment and I was in the middle of treatment when Anthem stopped the coverage of viscosupplementation. I was not notified of the coverage change by Anthem which happened during my 2017 coverage period. Despite my letters to Anthem and the Office of Healthcare Advocate, Anthem has not reinstated coverage.

By supporting this bill, you will be helping me and most likely others, to continue receiving this non-surgical treatment, allowing me to remain active, mobile and productive at my place of employment without resorting to dangerous addictive opioids, which are not an option as my work involves FAA Safety Sensitive . Thank you."

Connecticut citizens purchase health insurance and agree to pay monthly premiums for a year's worth of coverage promised and detailed in the benefits package. Currently an insurance company can change the formulary mid-year, but the consumer is not allowed to switch insurance companies. Why is the insurance company allowed to make changes during the contracted period, taking away a covered benefit, while the consumer is still expected to pay the same monthly premium? This constitutes a "bait and switch" tactic by a powerful industry that needs to be stopped immediately and penalized appropriately.

Insurance companies that sell health insurance coverage in our State should only be able to change the formulary and/ or coverage for prescription at the time of open enrollment with 90 days prior notice. Most plans are effective January 1st and a carrier would be required to give notification by the previous October 1st. This notification should be sent to the covered individual(s) via certified mail to ensure receipt. Our Society proposes the 90 days advanced notification, prior to open enrollment, to give ample notice for a consumer to investigate other options so they are fully informed when purchasing and/or renewing their health insurance.

Our Society fully supports no formulary changes during a coverage period unless the FDA removes or adds a prescription medication to the market. Furthermore, we request that consumer transparency is ensured by mandating insurers give 90 days' notice prior to the enrollment period on what will be covered in the next insurance coverage year in order for patients to make the best decision for them and their loved ones. Please support both HB 5366 and HB 5361 bills and ensure that our patients, your constituents, receive the coverage they contract for and that they and their employers pay for.

Thank you.
Respectfully submitted,
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